

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10303  
Registrar's No. 266

Registration District No. 84

Primary Registration District No. 5127

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town Rural Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
County Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3  
(Specify whether  
In this community 60 years  
years, months or days)

3. (a) PRINT FULL NAME William C. Schaub 100

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Susan W. Schaub 6. (c) Age of husband or wife if alive 16 years  
7. Birth date of deceased Feb. 16 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 19 If less than one day hr. 1 min.

9. Birthplace Gohanna Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

12. Name Nicholas Schaub  
13. Birthplace unknown Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant L.G. Schaub  
(b) Address 1017 Troost Kansas City, Mo.  
17. (a) burial (b) Date thereof Mar 6th 40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director FLEEMAN & SON, INC.  
(b) Address 1946 Calhoun St. Joseph, Mo.  
19. (a) MAY 6, 1940 (b) H.J. Neelbush  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan  
(c) City or town Rural  
(If outside city or town limits write "RURAL")  
(d) Street No. County Infirmary  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 5th.  
year 1940 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 16th to Mar 3, 1940  
that I last saw him alive on Mar 1st, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
General Arterio Sclerosis  
Arterio Sclerosis Coronary  
Arterio  
Interstitial Nephritis  
Due to \_\_\_\_\_ Duration None  
Due to \_\_\_\_\_ Know

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 121  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 85  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. E. Holley (M. D. or other) 1/6/40  
Address 822 Edmond St. Joseph Date signed 3/6/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*C. H. Swan*

Licensed Embalmer No. *4982*

P. O. Address *St. Joseph*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**